

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

43669

1. PLACE OF DEATH

County Reynolds

Registration District No. 749

Township 2

Primary Registration District No. 2984

City 2

(No. 2)

File No. 15

Registered No. 10

St. Ward

2. FULL NAME

Mary Jane Camden

(a) Residence, No. Leateville Rural

Length of residence in city or town where death occurred yrs. 0 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Infant

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 22, 1940

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 7 10

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Fork mo.

13. NAME Shelton Camden

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Red Point mo.

15. MAIDEN NAME Rattie Holt

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Fork mo.

17. INFORMANT Rattie Camden (ADDRESS) West Fork mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE West Fork mo. DATE Dec. 3, 1940

19. UNDERTAKER none (ADDRESS)

20. FILED Dec. 12 1940 C. M. Fitzpatrick Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 2 1940

22. I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1940, to Dec. 2 1940

I last saw her alive on Dec. 1 1940. Death is said to have occurred on the date stated above, at 5:30 P. m.

The principal cause of death and related causes of importance were as follows:

influenza Date of onset 11/12

Other contributory causes of importance: meningitis (due to the germs of influenza)

Name of operation Chloroform Date of 11/12 What test confirmed diagnosis? Chloroform Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury Where did injury occur? (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Nature of injury

24. Was disease or injury in any way related to occupation of deceased? If so, specify (Signed) C. M. Fitzpatrick M. D. (Address) Leateville, Mo.

RECEIVED

District Health Officer No 5,

District File Number 14189

Date Filed _____